NAVIGATING YOUR STATE HEALTH BENEFIT PLAN

Active Employee Decision Guide 2011

OPEN ENROLLMENT PERIOD
OCTOBER 12 – NOVEMBER 10, 2010

Georgia Department of Community Health

Phone Numbers/Contact Information

State Health Benefit Plan (SHBP): www.dch.georgia.gov/shbp

Vendor	Member Services	Website
CIGNA HRA, HMO, HDHP hours 24 hours 7 days a week	800-633-8519 TDD 800-576-1314	www.mycigna.com/shbp
UnitedHealthcare Definity HRA HMO, HDHP hours 8 am – 8 pm local time zone; Monday-Friday, TTY 711	800-396-6515 877-246-4189 TDD 800-255-0056	www.welcometouhc.com/shbp
SHBP Eligibility	404-656-6322 800-610-1863	www.dch.georgia.gov/shbp

Disclaimer: The material in this booklet is for informational purposes and is not a contract. It is intended only to highlight principal benefits of the medical plans. Every effort has been made to be as accurate as possible; however, should there be a difference between this information and the Plan documents, the Plan documents govern. It is the responsibility of each member, active or retired, to read all Plan materials provided in order to fully understand the provisions of the option chosen. Availability of SHBP options may change based on changes in federal or state law.

Page 3 of this guide contains Plan changes effective January 1, 2011. Prior to the start of the 2011 Plan Year, or shortly thereafter, the Plan will post a new Summary Plan Description (SPD) for each Plan option to the DCH website, www.dch.georgia.gov/shbp. The SPD is your official notification of Plan changes effective January 1, 2011. You may print or request a paper copy by calling the Customer Service number on the back of your ID card. Please keep your SPD for future reference. If you are disabled and need this information in an alternative format, call the TDD Relay Service at (800) 255-0056 (text telephone) or (800) 255-0135 (voice) or write the SHBP at P.O. Box 1990, Atlanta, GA 30301-1990.

Georgia Department of Community Health

Clyde L. Reese, III, Esq., Commissioner Sonny Perdue, Governor

2 Peachtree Street, NW
Atlanta, GA 30303-3159
www.dch.georgia.gov

October 1, 2010

Dear State Health Benefit Plan (SHBP) Member:

Welcome to the 2011 Open Enrollment. This year the Open Enrollment will be held October 12 - November 10, 2010. Employees will again make their health election on the Web at www.oe2011.ga.gov.

I first want to congratulate you for taking steps over the past year to lead healthier lifestyles. More than 10% of SHBP members and covered spouses benefited from our expanded wellness services by signing up for wellness coaching, completing their online health assessments and participating in worksite and other targeted wellness initiatives. These steps will ultimately lead to a healthier you and a healthier Georgia.

While we have seen great successes in our plan over the past year, SHBP has not been immune to the state's budget reductions that affect the revenue coming into the health plan. Plan reserves have been diminished and as a result benefit adjustments and premium increases have been necessary to assure financial stability of the plan.

SHBP is also impacted by the health care reform legislation that became law on March 23, 2010. While provisions of this Act will enhance your plan through expanded coverage for preventive care services and extended dependent coverage for children, these provisions have an impact on costs to the health plan in 2011. The costs of most of the health care reform provisions are being shared across the board by all members.

As you can see there will be a number of changes for active members. It is very important that you read the Decision Guide carefully before making your benefit selection. The Georgia Department of Community Health will continue to seek to provide you with cost-effective options and tools to help you make the best decisions for you and your family members.

Sincerely,

Clyde L. Reese, III, Esq.
Commissioner

Equal Opportunity Employer

Welcome to the Open Enrollment Period (OE) for the State Health Benefit Plan for coverage effective January 1, 2011–December 31, 2011

The OE dates are October 12 through November 10, 2010. This guide will provide you with a brief explanation of each Plan option and information about changes that will impact all members. It is very important that you carefully read the Decision Guide before making your election for the 2011 Plan Year. This book, Plan rates and other information can be found at www.dch.georgia.gov/shbp or www.oe2011.ga.gov. To help you navigate the book, the Guide is divided into seven sections.

While CIGNA and UnitedHealthcare's basic plan design is the same for each option, each vendor has nuances in benefits and services that are unique to each option. It is important that you read the Decision Guide so you will understand what these differences are and how they may affect you.

> Section 1 - Plan changes

> Section 2 - Understanding your plan options

> Section 3 - If you are retiring

> Section 4 - Benefits comparison

> Section 5 - Health & Wellness

> Section 6 - SHBP Eligibility

> Section 7 - Legal Notices

Be sure you review the Benefits Comparison charts on pages 12-15.

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>> SECTION 1 - Plan changes

STOP!

IMPORTANT INFORMATION!

The changes listed below apply to all SHBP members.

- If you have a natural or adopted child or stepchild under age twenty-six, you are the legal guardian for a child under age twenty-six, or have a child who may meet the requirements of a totally disabled child, carefully read the new dependent eligibility rules and decide whether to enroll the child in the SHBP. Be sure to select a tier that includes children. The OE dates are October 12 – November 10. Coverage will be effective on January 1, 2011. For more information contact the SHBP Call Center at 404-656-6322 or 800-610-1863 or refer to pages 17-18 for SHBP eligibility definitions and rules.
- The life-time maximum benefit limit is being removed
- Wellness benefits have been expanded
- Pre-existing no longer applies to any of the SHBP plans
- There will be an increase in premiums
- The Open Access Plan (OAP) will no longer be offered
- If you are in the OAP, contact your health care vendor prior to December 31, 2010 to see if you qualify for transition of care (i.e. current treatments such as chemotherapy, certain scheduled surgeries, etc.)
- All SHBP members will receive new ID cards before January 1, 2011
- The names of the four tiers have changed to:
  ■ You ■ You + Spouse ■ You + Child(ren) ■ You + Family*
- Tobacco surcharges have been increased to $80 per month and Spousal surcharges have been increased to $50 per month (see page 5 for information on how to have the surcharges removed)
- There are changes in co-payments, deductibles, out-of-pocket maximums, etc., as outlined below

* Family means you + spouse + children

HMO PLAN BENEFIT CHANGES		
Deductible	**2010**	**2011**
You	$600	$1,000
You + Spouse	$900	$1,500
You + Child(ren)	$900	$1,500
You + Family	$1,200	$2,000
Out-of-Pocket Maximum	**2010**	**2011**
You	$2,000	$3,000
You + Spouse	$3,000	$4,500
You + Child(ren)	$3,000	$4,500
You + Family	$4,000	$6,000
Specialist Office Visit	**2010**	**2011**
Co-payment	$35	$45
Pharmacy	**2010**	**2011**
Tier 1	$15	$20
Tier 2	$40	$50
Tier 3	$75	$90

Continued from page 3

HRA PLAN BENEFIT CHANGES		
Deductible	**In-Network/Out-of-Network 2010**	**In-Network/Out-of-Network 2011**
You	$1,100	$1,300
You + Spouse	$1,900	$2,250
You + Child(ren)	$1,900	$2,250
You + Family	$2,750	$3,250
Out-of-Pocket Maximum	**In-Network/Out-of-Network 2010**	**In-Network/Out-of-Network 2011**
You	$2,500	$3,000
You + Spouse	$4,100	$5,000
You + Child(ren)	$4,100	$5,000
You + Family	$5,700	$7,000

HDHP PLAN BENEFIT CHANGES				
Deductible	**In-Network 2010**	**In-Network 2011**	**Out-of-Network 2010**	**Out-of-Network 2011**
You	$1,200	$1,500	$2,400	$3,000
You + Spouse	$2,400	$3,000	$4,800	$6,000
You + Child(ren)	$2,400	$3,000	$4,800	$6,000
You + Family	$2,400	$3,000	$4,800	$6,000
Out-of-Pocket Maximum	**In-Network 2010**	**In-Network 2011**	**Out-of-Network 2010**	**Out-of-Network 2011**
You	$1,800	$2,400	$4,000	$5,300
You + Spouse	$3,100	$4,100	$7,400	$9,800
You + Child(ren)	$3,100	$4,100	$7,400	$9,800
You + Family	$3,100	$4,100	$7,400	$9,800

Impact of Healthcare Reform

Some changes for 2011 are the result of the Patient Protection and Affordable Care Act of 2010. The SHBP will now cover a member's child up to age 26, regardless of the child's marital, employment or student status, and regardless of whether the child lives with the member or is financially dependent on the member. The SHBP will now cover 100 percent of the cost of preventive treatments and screenings. The SHBP has eliminated all pre-existing condition requirements. The SHBP has eliminated all lifetime and annual limits for essential benefits.

Premiums for tiers that include dependent children have been increased to reflect the extra cost of covering newly eligible dependent children. However, the State continues to pay approximately 75 percent of the cost of coverage. The chart below shows the impact of the expanded dependent child coverage on premiums.

The rates below are for active employees.

	HRA			HMO			HDHP		
Employee Premiums	**2010**	**2011**	**Expanded Dependent Coverage Cost**	**2010**	**2011**	**Expanded Dependent Coverage Cost**	**2010**	**2011**	**Expanded Dependent Coverage Cost**
You	$62.50	$68.74	N/A	$100.20	$110.22	N/A	$54.40	$59.84	N/A
You + Spouse	$191.00	$210.10	N/A	$236.50	$260.14	N/A	$176.50	$194.14	N/A
You + Child(ren)	$185.30	$215.16	$11.33	$227.60	$264.26	$13.91	$171.40	$199.02	$10.48
You + Family	$196.60	$228.28	$12.02	$245.40	$284.94	$15.00	$181.60	$210.86	$11.10

STOP! IMPORTANT INFORMATION!

- You should read and understand SHBP's surcharge policy prior to making your health election for 2011
- The $80 Tobacco and $50 Spousal surcharges may apply based on your answers
- Intentional misrepresentation in response to surcharge questions will have significant consequences. You will lose State Health Benefit Plan coverage for 12 months beginning on the date that your false response is discovered

Spousal Surcharge

A $50 per month spousal surcharge will be added to your monthly premium if you elect to cover your spouse and your spouse is eligible for coverage through his/her employment, but chooses not to elect that coverage. You will automatically be charged the surcharge if you fail to answer all questions concerning the surcharge. The surcharge will apply to your premium for the 2011 Plan Year. If your spouse is eligible for coverage with SHBP through his/her employment, the spousal surcharge will be waived.

Please note that SHBP may audit any member covering a spouse who does not pay the spousal surcharge.

Tobacco Surcharge

A $80 per month tobacco surcharge will be added to your monthly premium if you or any of your covered dependents have used tobacco products in the previous 12 months or if you fail to answer these questions. The surcharge will apply to your premium for the 2011 Plan Year.

The tobacco surcharge may be removed by completing the tobacco cessation program requirements. Details are available at www.dch.georgia.gov/shbp. ***NOTE: No refunds for previously paid surcharges can be given.***

>> SECTION 2 - Understanding your plan options

IMPORTANT NOTE

If you change options or vendors during the year, any amounts applied toward your deductible or out-of-pocket are not transferred to the new option.

CIGNA and UnitedHealthcare Each Offer:

- HMO
- HRA
- HDHP

NOTE: If you are enrolling in coverage for the first time or if you have not been covered by SHBP during 2010, your options are limited to the HRA or the HDHP

Health Maintenance Organization (HMO)

A HMO allows you to obtain benefits from participating providers statewide and on a national basis across the United States. You are not required to select a Primary Care Physician (PCP). HMOs provide 100 percent benefit coverage for preventive health care needs with no co-payments. Certain services are subject to a deductible and co-insurance when seeing an in-network provider. *See pages 12-15 for more information.*

Plan Features

- You do not have to obtain a referral to see a Specialist (SPC); however, you are encouraged to select a PCP to help coordinate your care
- Coverage is available only when using in-network providers (except in cases of emergencies)
- Co-payments do not count toward your deductible or out-of-pocket maximum

Health Reimbursement Arrangement (HRA)

The HRA is a Consumer Driven Health Plan option (CDHP) whose plan design offers you a different approach for managing your health care needs. This plan has a national network with in-network and out-of-network benefits. The SHBP funds dollar credits to your HRA each year to provide first dollar coverage for eligible health care and pharmacy expenses. Unused dollars in your HRA account roll over to the next Plan year if you are still participating in this option, but will be forfeited if you change options during the OE or due to a qualifying event.

Plan Features

- The plan offers unlimited wellness benefits based on national age and gender guidelines when seeing in-network providers only
- HRA dollar credits are part of this option only and can only be used with the HRA option
- The amount in your HRA is used to reduce the deductible and maximum out-of-pocket
- There is not a separate deductible and out-of-pocket maximum for out-of-network expenses
- Out-of-pocket limit includes covered prescription drugs
- After satisfying your deductible, you will pay your co-insurance amount until you reach your out-of-pocket maximum.
- Certain drug costs are waived if SHBP is primary and you participate and remain compliant in one of the Disease State Management Programs (DSM) for Diabetes, Asthma and/or Coronary Artery Disease
- If you enroll in this Plan after the 1st of the year, your HRA dollars are pro-rated but the deductibles are not

High Deductible Health Plan (HDHP)

The HDHP option offers in-network and out-of-network benefits and provides access to a network of providers on a statewide and national basis across the United States. This Plan has a low monthly premium, and you must satisfy a high deductible that applies to all health care expenses except preventive care. **If you cover dependents, you must meet the ENTIRE deductible before benefits are payable for any covered member. You pay co-insurance after you have satisfied the deductible rather than set dollar co-payments for medical expenses and prescription drugs.** Also, you may qualify to start a Health Savings Account (HSA) to set aside tax-free dollars to pay for eligible health care expenses now or in the future. HSAs typically earn interest and may even offer investment options. *See the Benefits Comparison chart that starts on page 12 to compare benefits under the HDHP to other Plan options.*

Plan Features

- This option offers 100 percent unlimited wellness benefits based on national age and gender guidelines when seeing an in-network provider
- You must satisfy a separate in-network and out-of-network deductible and out-of-pocket maximum
- You pay co-insurance after meeting the entire deductible for all medical expenses and prescriptions until the out-of-pocket maximum is met
- **This plan is not creditable. That means if you don't sign up for Medicare when you first become eligible; you may be charged a late enrollment penalty. See the legal notice for more information**

Health Savings Account (HSA) – Information Only

An HSA is like a personal savings account with investment options for health care, except it's all tax-free. You may open an HSA with a bank or an independent HSA administrator/custodian.

You may open an HSA if you enroll in the SHBP HDHP and do not have other coverage through: 1) Your spouse's employer's plan 2) Medicare 3) Medicaid; or 4) General Purpose Health Care Spending Account (GPHCSA) or any other non-qualified medical plan. SHBP does not offer an HSA account.

- You can contribute up to $3,050 single, $6,150 family as long as you are enrolled in the HDHP. These limits are set by federal law. Unused money in your account carries forward to the next Plan year and earns interest
- HSA dollars can be used for eligible health care expenses even if you are no longer enrolled in the HDHP or any SHBP coverage
- HSA dollars can be used to pay for health care expenses (medical, dental, vision, and over-the-counter medications when a doctor states they are medically necessary) that the IRS considers tax-deductible that are NOT covered by any health plan (see IRS Publication 502 at www.irs.gov)
- You can contribute an additional $1,000 if you are 55 or older (see IRS Publication 969 at www.irs.gov)
- Non-qualified distribution excise tax increases from 10 to 20%

HRA AND HSA CONSIDERATIONS

	HRA	HSA
Overview	A tax-exempt account that reimburses retirees and dependents for qualified medical expenses. Can be funded by employer only.	A tax-exempt custodial account that exclusively pays for qualified medical expenses of the employee and his or her dependents. Can be funded by retiree, employer, or other party.
Who is eligible?	Available to SHBP members enrolled in an HRA. See benefits chart for amounts funded by SHBP.	Available to SHBP members who elect HDHP and may enroll in an HSA of your choice.
Can I have other general medical insurance coverage and take advantage of this benefit?	Yes.	No.
Who owns the money in these accounts?	SHBP. Money reverts back to SHBP upon loss of SHBP HRA coverage.	The member.
Can these dollars be rolled over each year?	Yes.	Yes.
Is there a monthly service charge?	No.	Check with your HSA administrator.
If I terminate my SHBP coverage or change options...	Unused amounts can be distributed until depleted to pay for HRA claims incurred before termination.	Fund disbursement is not tied to individual's employment. Unused amounts can be distributed tax-free for qualified medical expenses. Subject to income and excise tax for non-qualified expenses.

Who Must Participate in Open Enrollment?

EVERYONE who:

- Is currently enrolled in OAP
- Wants to continue current health coverage and not pay unnecessary surcharges
- Plans to change coverage tiers
- Needs to add or disenroll eligible dependents
- Needs to change health coverage options
- Plans to discontinue coverage
- Needs to enroll for health coverage
- Plans to retire during the year. Carefully review the "If you are retiring" pages 10-11.

What Should I Do Before I Make My 2011 Benefit Election?

- Evaluate your health care needs
- Carefully review the changes to SHBP options
- Compare the benefits under each option in relation to the premiums
- Verify your provider(s) will be participating in the option you choose
- Check the distance you will have to drive to see your provider(s)
- Check the Preferred Drug Lists to see if your prescriptions are covered and at what co-payment or co-insurance level
- If you currently have the HRA and change to the HDHP or HMO option, any unused HRA dollars will be forfeited

IMPORTANT NOTE

The tier selected during OE is valid for the entire plan year unless you experience a qualifying event that allows you to make a change. This includes when dependents are added during OE and documentation is not submitted.

Who Should I Contact if I Have Benefit Questions?

- Contact CIGNA Customer Service Line 800-633-8519
- UHC HMO, HDHP 877-246-4189
- UHC HRA 800-396-6515

How Can I Make My 2011 Health Insurance Election?

You will need to make your health election on www.oe2011.ga.gov, print your confirmation and make sure it contains a confirmation number. This number confirms your health benefit election for 2011. Contact your personnel/payroll office to obtain information regarding your flexible benefits.

- You may go online at www.oe2011.ga.gov; 4 a.m. October 12 – 4:30 p.m. November 10
- If you are unable to access the site, contact your personnel/payroll office
- Make sure you select the correct option and tier you wish to have for the 2011 Plan Year
- Verify that you correctly answered the Tobacco and Spousal surcharge questions if they are presented
- Verify your dependents and make sure you add any eligible dependents under age 26 you wish to cover
- Remember to click CONFIRM to finalize your election
- Print or save your confirmation page
- Remember a confirmation number will be shown once your election has been processed. You should copy this number and keep it in a safe place
- Your election must be made by the end of the OE at 4:30 p.m. on November 10, 2010
- You may go online multiple times; however, the last option confirmed at the close of OE will be your option for 2011 unless you experience a qualifying event that allows you to make a change
- Please do not wait until the last minute. Web traffic and SHPB phone volumes are unusually heavy near the end of OE

PLEASE READ!

State Personnel Administration (SPA) Flexible Benefits Program Participants

- Flexible Benefits Annual Enrollment. If you are eligible to make benefits elections under the Flexible Benefits Program, administered by the State Personnel Administration (SPA), please visit www.GaBreeze.ga.gov or call 3GBreez (877-342-7339) to make annual enrollment benefits elections. After confirming your elections online, print your confirmation showing your successful completion and keep it for your records. If you choose to call GaBreeze to make your benefit elections, you may request a confirmation be mailed to you.
- State Health Benefit Health Election. From the GaBreeze website, you have the ability to link to the State Health Benefit Plan (SHBP) for making your health election or may link directly to the SHBP at www.oe2011.ga.gov. After you complete your health election, print your confirmation page that contains your confirmation number and shows your successful completion.

Board of Education or Agencies Not Participating in the SPA Flexible Benefits Program

- Since you are not a participant of the State of Georgia Flexible Benefits Program, you will make your health election on www.oe2011.ga.gov. After you make your health election, print your confirmation and make sure it contains a confirmation number. This number confirms your health benefit election for the 2011 Plan Year. Contact your personnel/payroll office to obtain information regarding your other flexible benefits sponsored by your Board of Education.

What Happens if I Don't Go Online During Open Enrollment?

- If you are enrolled in a CIGNA or UHC option, your coverage will roll over to the same option and you will be assessed the Tobacco surcharge and the Spousal surcharge (if you cover your spouse)
- If you are currently enrolled in the OAP and do not make an election, your coverage will roll into the HRA and the Tobacco surcharge and the Spousal surcharge (if you cover your spouse) will apply

PLEASE READ!

- Dual coverage (more commonly referred to as State on State coverage) is when two members are eligible for coverage both as an employee and spouse under SHBP. For example: a member is eligible for SHBP coverage through his/her employment and his/her spouse is also eligible for SHBP coverage as an employee.
- If both members are eligible for coverage as employees, it may not be cost effective to cover each other as dependents. This is because regardless of the other coverage (SHBP or another group policy) you will still be responsible for co-payments, deductibles and non-covered or ineligible charges.

>> SECTION 3 - If you are retiring

What You Need to Know if You are Retiring

- If you want to continue your SHBP health insurance coverage after you retire, you and any dependents you want covered must be enrolled in the coverage at the time you retire (please refer to the Retiree Decision Guide for detailed information)
- Effective January 1, 2011 retirees will have the same four tier coverage selection as active members have currently. They are: You, You + Spouse, You + Child(ren), You + Family*
- If you are retiring and under age 65, the Tobacco surcharge and Spousal surcharge will apply the same as for active members
- Once retired, you will have an annual Retiree Option Change Period (ROCP) that allows you to change your Plan option only. You may add dependents ONLY within 31 days of a qualifying event.
- SHBP will remain your primary coverage until you or any of your covered dependents become eligible for Medicare
- The premiums you pay and your options change when you or one of your dependents become eligible for Medicare because of age (65 years) or disability
- You will pay a monthly premium for this coverage to Social Security. You must continue to pay this Part B premium to be eligible for a Medicare Advantage option.

General Medicare Information and SHBP Medicare Policy

Medicare is the country's health care system for individuals at age 65 or those with certain disabilities. Medicare includes Parts A - hospitalization, B - provider services and D - prescription drugs.

State Health Benefits Plan Medicare Policy

SHBP Medicare Policy requires all retirees and spouses eligible for Medicare because of age to enroll in one of the four Medicare Advantage PPO options offered through CIGNA /Humana Alliance and UnitedHealthcare (UHC) in order to continue to receive the State contribution to the cost of premiums. We will refer to these options as the MA options. To enroll in a MA option, you must at least have Medicare Part B coverage.

- You should enroll for Medicare when you first become eligible and should mail a copy of your Medicare card to SHBP, P.O. Box 1990, Atlanta, GA 30301 or fax to a secure fax line at 866-828-4796. To allow time for processing and to avoid paying higher premiums, you should submit this information by the first of the month prior to the month you turn age 65. Upon receipt, SHBP will adjust your premiums to reflect your Medicare
- Members and/or their dependents eligible due to disability will be responsible for notifying SHBP of their Medicare enrollment as soon as they are eligible
- SHBP is not able to refund premiums when notification is not received timely
- SHBP will pay primary benefits on members not enrolled in Medicare but you will pay 100 percent of the cost of your SHBP premiums. Premiums will range from $1,300 to $2,400 per month
- Family members not eligible for the MA will keep their current option. This is called split eligibility

What if I Have End Stage Renal Disease (ESRD) ?

If you have Medicare due to End Stage Renal Disease (ESRD), you will need to contact the Social Security Administration to determine when Medicare becomes primary.

Medicare information is available at:

- www.cms.hhs.gov
- www.medicare.gov
- www.ssa.gov
- 1-800-669-8387 (Georgia Cares)
- 1-800-633-4227 (Medicare)
- Please send SHBP a copy of the notification from Social Security of your start date to P.O. Box 1990, Atlanta, GA 30301-1990. If you are under 65, eligible for Medicare due to ESRD, in your 30 month coordination period and wish to enroll in a Medicare Advantage option you must select the Humana option offered by SHBP through the CIGNA/Humana alliance. Both vendors can offer Medicare Advantage after the 30 month coordination period ends for ESRD.

* Family means you + spouse + children

What if I Am Working and Am Eligible for Medicare?

Federal Law requires SHBP to pay primary benefits for active employees and their dependents. Active members or their covered dependents may choose to delay Medicare enrollment. Termination of active employment is a qualifying event for enrolling in Medicare without penalty if your plan is creditable. Remember the HDHP plan is NOT creditable. To avoid the penalty, you should enroll in a creditable plan at Open Enrollment if someone under your coverage will turn 65 during the plan year and they will not be enrolling in Medicare due to your active employment.

IMPORTANT NOTE

- There is critical information about SHBP options and premiums for retirees in the retiree decision guide. It is your responsibility for reading this information.
- The HDHP is not considered a creditable plan.
- If you delay Medicare enrollment because you are still working, there is no penalty for enrolling when you retire unless you are enrolled in the HDHP option. You will be charged a Late Enrollment Penalty (LEP) if you don't enroll when first eligible.
- If you have questions about your SHBP options and premiums when you plan to retire, call the SHBP Call Center at 404-656-6322 or 800-610-1863.

What Happens if I Have the HRA and Move to the MA PPO Option?

- Any outstanding funds in the HRA $10 or more will be moved to a stand alone HRA account to be used toward any out-of-pocket expenses

Benefits Comparison: HRA – HDHP – HMO

Schedule of Benefits for You and Your Dependents for January 1, 2011 –December 31, 2011

	HRA OPTION		HDHP OPTION		HMO OPTION
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Covered Services					
Deductible/Co-Payments • You • You + Spouse • You + Child(ren) • You + Family	$1,300* $2,250* $2,250* $3,250* **HRA credits will reduce this amount*		$1,500 $3,000 $3,000 $3,000	$3,000 $6,000 $6,000 $6,000	$1,000 $1,500 $1,500 $2,000
Out-of-Pocket Maximum • You • You + Spouse • You + Child(ren) • You + Family	$3,000* $5,000* $5,000* $7,000* **HRA credits will reduce this amount*		$2,400 $4,100 $4,100 $4,100	$5,300 $9,800 $9,800 $9,800	$3,000 $4,500 $4,500 $6,000
HRA Credits • You • You + Spouse • You + Child(ren) • You + Family	$500 $1,000 $1,000 $1,500		None		None
Physicians' Services	*The Plan Pays*		*The Plan Pays*		*The Plan Pays*
Primary Care Physician or Specialist Office or Clinic Visits Treatment of illness or injury	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible	100% after a $35 PCP or $45 SPC per office visit co-payment
Primary Care Physician or Specialist Office or Clinic Visits for the Following: • Wellness care/preventive health care • Annual gynecological exams(these services are not subject to the deductible)	100% coverage; not subject to deductible	Not covered	100% coverage; not subject to deductible	Not covered	100% coverage; not subject to deductible
Maternity Care (prenatal, delivery and postpartum)	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible	100% after initial $35 co-payment
Physician Services Furnished in a Hospital • Visits; surgery in general, including charges by surgeon, anesthesiologist, pathologist and radiologist	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible

Benefits Comparison: HRA – HDHP – HMO

Schedule of Benefits for You and Your Dependents for January 1, 2011 –December 31, 2011

	HRA OPTION		HDHP OPTION		HMO OPTION
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Physicians' Services	*The Plan Pays*		*The Plan Pays*		*The Plan Pays*
Physician Services for Emergency Care Non-emergency use of the emergency room not covered	85% coverage; subject to deductible		90% coverage; subject to in-network deductible		100% ($150 co-payment applies to facility expenses)
Outpatient Surgery • When billed as office visit	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible	100% ($35 PCP or $45 SPC co-payment if billed as office visit)
Outpatient Surgery • When billed as outpatient surgery at a facility	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible
Allergy Shots and Serum	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible	100% for shots and serum after a $35 PCP or $45 SPC per visit co-payment; no co-payment if office visit not billed
Hospital Services	*The Plan Pays*		*The Plan Pays*		*The Plan Pays*
Inpatient Services • Inpatient care, delivery and inpatient short-term acute rehabilitation services	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible
Inpatient Services • Well-newborn care	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage; not subject to deductible
Outpatient Surgery Hospital/facility	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible
Emergency Care—Hospital • Treatment of an emergency medical condition or injury • Non-emergency use of the emergency room not covered	85% coverage; subject to deductible		90% coverage; subject to in-network deductible		100% after a $150 per visit co-payment; if admitted, co-payment waived; 80% coverage; subject to deductible
Outpatient Testing, Lab, etc.	*The Plan Pays*		*The Plan Pays*		*The Plan Pays*
Non Routine laboratory; X-Rays; Diagnostic Tests; Injections—including medications covered under medical benefits—for the treatment of an illness or injury	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible

Benefits Comparison: HRA – HDHP – HMO

Schedule of Benefits for You and Your Dependents for January 1, 2011 –December 31, 2011

	HRA OPTION		HDHP OPTION		HMO OPTION
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Behavioral Health	*The Plan Pays*		*The Plan Pays*		*The Plan Pays*
Mental Health and Substance Abuse Inpatient Facility and Partial Day Hospitalization NOTE: Contact vendor regarding prior authorization	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible
Mental Health and Substance Abuse Outpatient Visits and Intensive Outpatient NOTE: Contact vendor regarding prior authorization	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible	100% after $35 PCP or $45 SPC per visit co-payment. UHC – $10 co-payment for group therapy
Dental	*The Plan Pays*		*The Plan Pays*		*The Plan Pays*
Dental and Oral Care NOTE: Coverage for most procedures for the prompt repair of sound natural teeth or tissue for the correction of damage caused by traumatic injury	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible	100% after $45 SPC per visit co-payment; if inpatient/ outpatient facility, 80% subject to deductible
	NOTE: Notification required for all UHC options.				
Temporomandibular Joint Syndrome (TMJ) NOTE: Coverage for diagnostic testing and non-surgical treatment up to $1,100 per person lifetime maximum benefit. This limit does not apply to the HMO	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible	100% after $45 SPC co-payment for related surgery and diagnostic services; excludes appliances and orthodontic treatment; if inpatient/ outpatient facility 80% subject to deductible
Vision	*The Plan Pays*		*The Plan Pays*		*The Plan Pays*
Routine Eye Exam NOTE: Limited to one eye exam every 24 months	100% coverage; not subject to deductible	Eye exam not covered	100% coverage; not subject to deductible	Eye exam not covered	100% after $45 SPC co-payment; not subject to deductible. $200 annual benefit for glasses and contacts
Other Coverage	*The Plan Pays*		*The Plan Pays*		*The Plan Pays*
Hearing Services Routine hearing exam	85% coverage for routine exam and fitting; subject to deductible. $1,500 hearing aid allowance every 5 years; not subject to the deductible		90% coverage for route exam and fitting; subject to deductible. $1,500 hearing aid allowance every 5 years; subject to the deductible		Not covered
Ambulance Services for Emergency Care NOTE: "Land or air ambulance" to nearest facility to treat the condition	85% coverage; subject to deductible		90% coverage; subject to in-network deductible		100% coverage; not subject to deductible
Urgent Care Services NOTE: All subject to deductible except HMO	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible	100% after $35 co-payment

Benefits Comparison: HRA – HDHP – HMO

Schedule of Benefits for You and Your Dependents for January 1, 2011 –December 31, 2011

	HRA OPTION		HDHP OPTION		HMO OPTION
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Other Coverage	*The Plan Pays*		*The Plan Pays*		*The Plan Pays*
Home Health Care Services NOTE: Prior approval required	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage; UHC up to 120 visits; CIGNA up to 120 days per Plan year
Skilled Nursing Facility Services NOTE: Prior approval required	85% coverage; up to 120 days per Plan year; subject to deductible	Not covered	90% coverage up to 120 days per Plan Year; subject to deductible	Not covered	80% coverage; up to 120 days per Plan year; subject to deductible
Hospice Care NOTE: Prior approval required	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage; subject to deductible
Durable Medical Equipment (DME)—Rental or purchase NOTE: Prior approval required for certain DME	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage when medically necessary
Outpatient Acute Short-Term Rehabilitation Services • Physical Therapy • Speech Therapy • Occupational Therapy • Other short term rehabilitative services NOTE: 40 visits per therapy	85% coverage; subject to deductible; up to 40 visits per therapy per Plan year (not to exceed a total of 40 visits combined, including any out-of-network visits)	60% coverage; subject to deductible; up to 40 visits per therapy per Plan year (not to exceed a total of 40 visits combined, including any in-network visits)	90% coverage up to 40 visits per therapy per Plan year; subject to deductible (not to exceed a total of 40 visits combined, including any out-of-network visits)	60% coverage up to 40 visits per therapy per Plan year; subject to deductible (not to exceed a total of 40 visits combined, including any in-network visits)	100% coverage after $25 per visit co-payment; up to 40 visits per therapy per Plan year
Chiropractic Care NOTE: UHC Coverage up to a maximum of 20 visits; CIGNA – up to a maximum of 20 days, per plan year	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage after $35 PCP or $45 SPC co-payment per visit
Foot Care NOTE: Covered only for neurological or vascular diseases	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage after $35 PCP or $45 SPC co-payment per visit
Transplant Services NOTE: Prior approval required	Contact vendor for coverage details	Contact vendor for coverage details	Contact vendor for coverage details	Contact vendor for coverage details	Contact vendor for coverage details
Pharmacy - You Pay					
Tier 1 Co-payment NOTE: No Tiers in HRA Option	15% generic; 25% brand; subject to deductible	40% generic; 40% brand; subject to deductible*	20% coverage; subject to deductible $10 min./ $100 max.	Not covered	$20
Tier 2 Co-payment Preferred Brand	Not applicable	Not applicable	20% coverage; subject to deductible $10 min./$100 max.	Not covered	$50
Tier 3 Co-payment Non-Preferred Brand	Not applicable	Not applicable	20% coverage; subject to deductible $10 min./$100 max.	Not covered	$90
Tier 4 Co-payment	Not applicable	Not applicable	Not Applicable	Not covered	Not applicable

>> SECTION 5 - Health & Wellness

What Can You Do About Your Health?

Take a Personal Health Assessment at least once a year to assist you in learning about potential health risks related to your lifestyle and family history. Each vendor has a health assessment questionnaire available on their website that you can complete. After completing the health assessment you will get a customized report that identifies health risks and provides recommendations on ways to help you reduce health risks and suggestions on how to make better lifestyle choices. *Members who complete the health assessment may be contacted by the vendor's registered nurses or health coaches regarding steps they can take to control or eliminate these risks.* **Participant data is completely confidential and individual results are not shared with your employer or SHBP. Members in the HRA who complete the Health Assessment will earn additional dollar credits.**

Utilize the Preventive Health and Wellness services. One of the best ways to stay healthy is to take advantage of preventive health care. Check with the vendor regarding the plan option you choose to confirm which preventive services are covered. In addition, each vendor offers health coaching and wellness programs such as weight loss, nutrition, and stress management and smoking cessation. Contact the vendors to learn more about the programs they offer or visit their website to view available services.

Engage in the Health Management Services. Each vendor offers assistance with health care services including disease management, case management and behavioral health. Please contact the vendor of choice for additional details on programs offered such as the DSM Program that waives prescription drug co-payments/costs on certain medications for members who have Cardiovascular Disease, Diabetes and/or Asthma and remain compliant with the DSM Program requirements.

Call the Nurse Advice Line. Each vendor has a 24-hour, seven days a week (including holidays) nurse advice line that is available to assist you in making informed decisions about your health. Check with your health plan option for the telephone number.

Good health is priceless. When you live a healthy lifestyle, you can feel better, live easier and save money on health care expenses!

DID YOU KNOW?

- Cardiovascular Disease is the leading cause of death in Georgia
- Diabetes in Georgia is 8% higher than the nation as a whole
- Asthma has been diagnosed in approximately 250,000 children in Georgia between the ages of 0–17 years old
- Certain drug costs are waived for HRA members who actively engage in the Disease State Management (DSM) Programs for Cardiovascular Disease, Diabetes or Asthma

>> SECTION 6 - SHBP Eligibility

The SHBP covers dependents who meet SHBP guidelines. Eligibility documentation must be submitted before SHBP can send notification of a dependent's coverage to the health care vendors.

Eligible Dependents Are:

1. **Spouse** – Individual who is not legally separated, who is of the opposite sex to the Enrolled Member and who is legally married or who submits satisfactory evidence to the Administrator of common law marriage to the Employee or Retiree entered into prior to January 1, 1997 and is not legally separated.
2. **Dependent Child** – An eligible Dependent child of an Enrolled Member must meet one of the following definitions:
   - **Natural child** – A natural child for which the natural guardian has not relinquished all guardianship rights through a judicial decree. Eligibility begins at birth and ends at the end of the month in which the child reaches age twenty-six (26).
   - **Adopted child** – Eligibility begins on the date of legal placement for adoption and ends at the end of the month in which the child reaches age twenty-six (26).
   - **Stepchild** – Eligibility begins on the date of marriage to the natural parent. Eligibility ends at the end of the month in which the child reaches age twenty-six (26), or at the end of the month in which the stepchild loses his or her status as stepchild of the Enrolled Member, whichever is earlier.
   - **Guardianship** – A child for whom the Enrolled Member is the legal guardian. Eligibility begins on the date the legal guardianship is established. Eligibility ends at the end of the month in which the child reaches age twenty-six (26), or at the end of the month in which the legal guardianship terminates, whichever is earlier. Certification documentation requirements are at the discretion of the Administrator. However, a judicial decree from a court of competent jurisdiction is required unless the Administrator concludes that documentation is satisfactory to establish legal guardianship and that other legal papers present undue hardship on the Member or living natural parent(s).
   - **Totally Disabled Child** – A natural child, legally adopted child or stepchild age twenty-six (26) or older, if the child was physically or mentally disabled before age twenty-six (26), continues to be physically or mentally disabled, lives with the Enrolled Member or is institutionalized, and depends primarily on the Enrolled Member for support and maintenance.

Making Changes When You Have a Qualifying Event

If you experience a qualifying event, you may be able to make changes for yourself and your dependents, provided you request the change within 31 days of the qualifying event. Also, your requested change must correspond to the qualifying event. For a complete description of qualifying events, see your Summary Plan Description. You can contact the Eligibility Unit for assistance at 800-610-1863 or in the Atlanta area at 404-656-6322. If you change options or vendors during the year, your deductible and out-of-pocket accumulation will start over.

Qualifying events include, but are not limited to:

- Birth or adoption of a child, or placement for adoption
- Change in residence by you or your spouse that results in ineligibility for coverage in your selected option because of location
- Death of a spouse or child, if the only dependent enrolled
- Your spouse's or dependent's loss of eligibility for other group health coverage
- Marriage or divorce
- Medicare eligibility

STOP! IMPORTANT INFORMATION!

- Please submit your change request, within 31 days of the qualifying event to SHBP. Requests should not be held waiting on additional information, such as Social Security Number, marriage or birth certificate
- SHBP will accept dependent verification at anytime during the plan year and coverage will be retroactive to the qualifying event date or first of the Plan Year, whichever is later

Documentation Confirming Eligibility for Your Spouse or Dependents

SHBP requires documentation concerning eligibility of dependents covered under the plan.

- **Spouse** – Certified copy of marriage license or copy of your most recent Federal Tax Return (filed jointly with spouse)including legible signatures for you and your spouse with financial information blacked out. The spouse's Social Security Number is also required
- **Natural or adopted child –** Certified copy of birth certificate or birth card issued by hospital which lists parents by name are accepted for new births and certified copy of court documents establishing adoption and stating date of adoption, or, if adoption is not finalized, certified or notarized legal documents establishing the date of placement for adoption. If a certified copy of the birth certificate is not available for an adopted child, other proof of the child's date of birth is required. The Social Security Number is required for all children two and older
- **Stepchild** – Certified copy of birth certificate showing your spouse is the natural parent of the child AND certified copy of marriage license showing the natural parent of the child is your spouse or a copy of your most recent Federal Tax Return (filed jointly with spouse) including legible signatures for you and your spouse with financial information blacked out. The Social Security Number is required for all children age two and older
- **Legal Guardianship** – Certified copy of court documents establishing the legal guardianship and stating the dates on which the guardianship begins and ends and a certified copy of the birth certificate or other proof of the child's date of birth. The Social Security Number is required for all children age two and older

PLEASE READ!

No health claims will be paid until the documentation is received and approved by SHBP.

The member's Social Security Number MUST be written on each document so we can match your dependents to your record. Do not send originals as they will not be returned.

COBRA Rights – Dependents of Active Members

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 requires that the Plan offer your spouse or an eligible dependent the opportunity to continue health coverage if Plan coverage is lost due to a Qualifying Event. The length of time one of your dependents may continue the coverage is based on the Qualifying Event. For further information refer to your SPD.

>> SECTION 7 - Legal Notices

About the Following Notices

The notices on the following pages are required by the Center for Medicaid & Medicare Services (CMS) to explain what happens if you retire and buy an individual Medicare Prescription Drug (Part D) Plan. The chart below explains what happens if you buy an individual Medicare Part D Plan.

Your SHBP Option	What happens if you buy an individual Medicare Part D Plan
SHBP Medicare Advantage PPO Standard or SHBP Medicare Advantage PPO Premium Plan	You will permanently lose SHBP coverage if you purchase a Part D Plan once enrolled in a SHBP Medicare Advantage Plan. You will not pay a Medicare "late enrollment" penalty
HRA /HMO	Your Medicare Part D Plan will be primary for your prescription drugs unless you are in the deductible or doughnut hole and then SHBP will provide benefits. If you reach the Out-of-pocket Limit, SHBP will coordinate benefits with your Medicare Part D Plan. You will not pay a Medicare "late enrollment" penalty
HDHP (High Deductible)	You will have to pay a Medicare "late enrollment" penalty if you miss the initial enrollment period because the HDHP option is not considered "creditable coverage"

These notices state that prescription drug coverage under all SHBP coverage options except for the HDHP (High Deductible) option is considered Medicare Part D "creditable coverage." This means generally that the prescription drug coverage under SHBP MA Standard, SHBP MA Premium, HMO and HRA are all "as good or better than" the prescription drug coverage offered through Medicare Part D plans that are sold to individuals.

Georgia Department of Community Health

Two Peachtree Street
Atlanta, GA 30303
(404) 656-6322 • (800) 610-1863

October 1, 2010

Important Notice from the SHBP about Your HDHP Prescription Drug Coverage and Medicare

About Your Prescription Drug Coverage with the CIGNA and UnitedHealthcare High Deductible Health Plan (HDHP) and Medicare

For Plan Year: January 1 – December 31, 2011

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the State Health Benefit Plan (SHBP) and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three (3) important things you need to know about your current coverage and Medicare's prescription drug coverage:

1 Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare prescription drug plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2 The SHBP has determined that the prescription drug coverage offered by the HDHP option, is on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered **Non-Creditable Coverage. This is important, because most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the HDHP offered by SHBP. This is also important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.**

3 You can keep your current coverage in a CIGNA or UnitedHealthcare HDHP offered by the SHBP. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including which drugs are covered, with the coverage and costs of the plans offering Medicare Prescription Drug Coverage in your area. *Read this notice carefully as it explains your options.*

When Can you Join a Medicare Drug Plan?

You can join a Medicare Drug Plan when you first become eligible for Medicare and each year from November 15th through December 31st. However, if you decide to drop your current coverage under SHBP, since it is an employer sponsored group plan; you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare Drug Plan; However, you also may pay a higher premium (a penalty) because you did not have Creditable Coverage under SHBP.

Buying any individual Medicare insurance product outside of the Medicare Advantage plans offered through SHBP could AUTOMATICALLY and PERMANENTLY END your SHBP Coverage.

When will you pay a Higher Premium (a Penalty) to Join a Medicare Drug Plan?
Since the HDHP coverage under SHBP, is not creditable, depending on how long you go without creditable prescription drug coverage, you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1 percent of the Medicare base beneficiary premium per month for every month that you did not have coverage. For example, if you go nineteen months without creditable coverage, your premium may be consistently 19 percent higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

What Happens to Your Current Coverage if you Decide to Join a Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current HDHP coverage under SHBP will be affected. If you enroll in Medicare Part D when you become eligible for Medicare Part D, you can keep your HDHP coverage and the HDHP will coordinate benefits with the Part D coverage. If you decide to join a Medicare Drug Plan and drop your HDHP coverage under SHBP, be aware that you and your dependents will not be able to get your SHBP coverage back if you are a retiree.

You should also know that if you drop or lose your HDHP coverage with SHBP and don't join a Medicare Drug Plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

For more information about this notice or your current prescription drug coverage...
Contact the SHBP Call Center at (404) 656-6322 or (800) 610-1863 for further information. NOTE: You will get this notice each year. You will also get it before the next period you can join a Medicare drug coverage, and if this coverage through SHBP changes. You may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage...
More detailed information about Medicare plans that offer prescription drug coverage is in the Medicare & You handbook. You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug plans:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the Medicare & You handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call (1-877-486-2048). 24 hours a day/7 days a week

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the Web at www.socialsecurity.gov, or call them at (1-800-772-1213). TTY users should call (1-800-325-0778).

Date: October 1, 2010
Name of Entity/Sender: State Health Benefit Plan
Contact: Call Center
Address: P.O. Box 1990, Atlanta, GA 30301
Phone Number: 404-656-6322 or 800-610-1863

Buying any individual Medicare insurance product outside of the Medicare Advantage plans offered through SHBP could AUTOMATICALLY and PERMANENTLY END your SHBP Coverage.

Georgia Department of Community Health

Two Peachtree Street
Atlanta, GA 30303
(404) 656-6322 • (800) 610-1863

October 1, 2010

Important Notice from the SHBP About Your Prescription Drug Coverage with the CIGNA and UnitedHealthcare HMO, HRA and Medicare

For Plan Year: January 1 – December 31, 2011

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the State Health Benefit Plan (SHBP) and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to learn about your current coverage and Medicare's prescription drug coverage:

1 Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2 The SHBP has determined that the prescription drug coverage offered by the CIGNA and UnitedHealthcare HMO and HRA offered under SHBP is, therefore, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is considered Creditable Coverage. **Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Do Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your SHBP coverage will be affected. You can keep your SHBP coverage if you elect Part D and SHBP will coordinate with Part D coverage the month following receipt of enrollment notice. You should send a copy of your Medicare cards to SHBP at P.O. Box 1990, Atlanta, GA 30301.

If you do join a Medicare drug plan and drop your coverage with SHBP, be aware that you and your dependents can not get this coverage back if you are a retiree.

Buying any individual Medicare insurance product outside of the Medicare Advantage plans offered through SHBP could AUTOMATICALLY and PERMANENTLY END your SHBP Coverage.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with SHBP and don't join a Medicare drug plan within 63 continuous days after your coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium will always be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information about this Notice or Your SHBP Current Prescription Drug Coverage...
Contact the SHBP Eligibility Unit at 404-656-6322 or 800-610-1863. NOTE: You will receive this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage, through SHBP changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage...
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans.

For more information about Medicare prescription drug plans:
- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the Medicare & You handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. 24 hours a day/7 days a week

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the Web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: October 1, 2010
Name of Entity/Sender: State Health Benefit Plan
Contact: Call Center
Address: P. O. Box 1990, Atlanta, GA 30301
Phone Number: 404-656-6322 or 800-610-1863

Buying any individual Medicare insurance product outside of the Medicare Advantage plans offered through SHBP could AUTOMATICALLY and PERMANENTLY END your SHBP Coverage.

Customer Service Survey

QUESTION	STANDARD	CIGNA Result	UHC Result
Customer Services			
What is the percentage of member calls that were answered within 30 seconds or less?	85%	87.5%	85.3%
What are the hours to speak with a live agent regarding benefits, claim processing, eligibility, etc.?	8:00am - 8:00pm Mon - Fri	24/7	8:00 - 8:00 Mon - Fri
What are the hours to speak with a Nurse?	24/7, Mon - Fri	24/7	24/7
What special recognition or honors have been received for call center quality and service?	Meets Industry Norm	J.D. Power	Best Health Provider
Claims			
What is the % of clean claims processed within 14 days?	90%	97%	99.6%
What is the % of all claims processed within 90 days?	99%	99.9%	99.7%
What is the financial accuracy rate for processing claims?	99%	99.4%	99.6%
Network in Georgia - Contracted Physicians and Hospitals			
What is the percent of members in urban areas with access to physicians within the mileage standard?	80%	95.1%	93%
What is the percent of members in the suburban areas have access to physicians within the mileage standard?	80%	100%	99.6%
What percent of members in rural areas have access to physicians within the mileage standard?	80%	98.5%	78.1%
What is the percentage of Voluntary Physician Turnover?	Less than 5.0%	0.39%	0.52%
What is the # of contracted Georgia Physicians?	Must meet Geographic access standards	16,587	16,030
What is the # of contracted Georgia Acute Hospitals?	Must meet Geographic access standards	152	153
Member Satisfaction			
What percentage of members rated their overall satisfaction level as Satisfied or Very Satisfied?	85%	92%	96%
Primary Physician Network What percentage of members rated the primary physician network as Good, Very Good or Excellent?	85%	96%	96%
Specialist Network What percentage of members rated the specialist physician network as Good, Very Good or Excellent?	85%	96%	96%
Hospital Network What percentage of members rated the hospital network as Good, Very Good or Excellent?	85%	95%	97%
Claim Paid Correctly What percentage of survey respondents rated the ability to pay claims correctly as Good, Very Good or Excellent?	85%	93%	96%
Representative was Helpful What percentage of members rated the ability of the customer service rep to provide specific directions to answers to address any claim issues or other problems?	85%	94%	93%
Representative was Courteous & Respectful What percentage of members rated the representative as courteous and respectful or very courteous and respectful?	85%	98%	97%
Representative was Knowledgeable about the Plan What percentage of members rated the representative as knowledgeable or very knowledgeable?	85%	92%	95%
Online Tools			
Online Tools Do you provide members the ability to search claims history, provider search, medical cost comparison, provider quality metrics, educational resources, Rx pricing comparison, etc.?	Provides on line access to tools	Yes	Yes
Quality			
Do you have accreditation by an external entity that rates quality?	Various	NCQA Excellent	NCQA Commendable
Do you have accreditation by an external entity that rates quality (Health Services & Case management)?	Various	URAC Full Accreditation	URAC Full Accreditation

Penalties for Misrepresentation

If an SHBP participant misrepresents eligibility information when applying for coverage, during change of coverage or when filing for benefits, the SHBP may take adverse action against the participants, including but not limited to terminating coverage (for the participant and his or her dependents) or imposing liability to the SHBP for fraud or indemnification (requiring payment for benefits to which the participant or his or her beneficiaries were not entitled). Penalties may include a lawsuit, which may result in payment of charges to the Plan or criminal prosecution in a court of law.

In order to avoid enforcement of the penalties, the participant must notify the SHBP immediately if a dependent is no longer eligible for coverage or if the participant has questions or reservations about the eligibility of a dependent. This policy may be enforced to the fullest extent of the law.

Common Acronyms

CDHP – Consumer Driven Health Plan

CMS – Centers for Medicare and Medicaid Services

COB – Coordination of Benefits

DCH – Georgia Department of Community Health

FSA – Flexible Spending Account

HDHP – High Deductible Health Plan

HMO – Health Maintenance Organization

HRA – Health Reimbursement Arrangement

HSA – Health Savings Account

IRS – Internal Revenue Service

MA (PPO) – Medicare Advantage Preferred Provider Organization

OE – Open Enrollment

PCF – Personalized Change Form

PCP – Primary Care Physician

ROCP – Retiree Option Change Period

SHBP – State Health Benefit Plan

SPC – Specialist

SPD – Summary Plan Description

UHC – UnitedHealthcare

Georgia Department of
Community Health